

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041993

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10314

FILED OCT 24 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>St. Louis</u> 39	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>6700 Odell</u>	

3. NAME OF DECEASED (Type or print) First <u>ANGELA</u> Middle <u>Lee</u> Last <u>SAUNDERS</u>			4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>63</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/63</u>	9. AGE (last birthday) <u>12</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>James D. Saunders</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Heuer</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>7511</u>		17. INFORMANT <u>James D. Saunders</u> Address <u>6700 Odell</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningoencephalitis</u> DUE TO (b) <u>Acute vaginal fistula</u> DUE TO (c) <u>Imperforate anus</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>7511</u>	
20c. TIME OF INJURY Hour <u>11:45</u> a.m. <u>PM</u> Month, Day, Year <u>9/20/63</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>9/20/63</u> to <u>10/15/63</u> and last saw her alive on <u>10/15/63</u> Death occurred at <u>11:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Michaelson M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>10/15/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/18/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	
24. FUNERAL DIRECTOR <u>Alexander & Sons</u>		ADDRESS <u>6175 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 16 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Roan Smith M.D.</u>		27. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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Rev. 4/59

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ST. LOUIS CITY BOARD OF HEALTH
ST. LOUIS, MO.

ANGELA
CHANDLER
TO
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03

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Vernon C. Velden

Licensed Embalmer No. 5031

P. O. Address 9801 Highway 66
Crestwood, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

REV. 1-2-54